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A clean bill of health? The efficacy of an NHS commissioned outsourced police custody healthcare service

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ABSTRACT

Police custody healthcare services for detainees in the UK are most commonly outsourced to independent healthcare providers who employ custody nurses and forensic physicians to deliver forensic healthcare services. A pilot was introduced in 2008 by the Department of Health to explore the efficacy of commissioning custody healthcare via the NHS, in the wake of the 2005–2006 shift of prison healthcare to the NHS. The objective was to improve quality and accountability through NHS commissioning and the introduction of NHS governance to the management and delivery of custody healthcare. This article discusses key themes that arose from the project evaluation, which focused on the commissioning relationship between the police, the NHS commissioner and the private healthcare provider. The evaluation observed an evolving relationship between the police, the local NHS and the front-line nurses, which was complicated by the quite distinctive professional values and ideologies operating, with their contrasting organisational imperatives and discordant values and principles. A key challenge for commissioners is to develop synergy between operational and strategically located stakeholders so that they can work effectively towards common goals. Government policy appears to remain focused on creating safe, supportive and humane custody environments that balance criminal justice and health imperatives and support the rights and needs of detainees, victims, professionals and the public. This remains an ambitious agenda and presents a major challenge for new criminal justice health partnerships.

1. Introduction

Police custody healthcare services in the United Kingdom have for many years been outsourced to independent healthcare providers who deploy custody nurses and forensic physicians (also formerly known as Forensic Medical Examiners [FMEs] or Police Surgeons) to police forces to deliver forensic, medico-legal and healthcare services for detainees and victims of crime. In 2008, the Department of Health decided to extend NHS commissioning from prison healthcare to police custody healthcare services.[1] The objective was not necessarily to switch to a service delivered by the NHS, but to introduce NHS commissioning as a means towards improving quality and accountability via a robust NHS governance framework for the procurement and delivery of custody healthcare.

This paper reports on an evaluation undertaken to examine the efficacy of delivering an NHS-commissioned outsourced police custody healthcare service. The commissioning pilot was set up by the Department of Health to inform future organisation and delivery of custody healthcare services in England. The evaluation examined the commissioning relationship between the police, the NHS and the private provider.

It should be emphasised that the terms 'detainee' and 'offender' are contested, imprecise concepts, commonly used to refer to people who come into contact with criminal justice systems because they are suspected to have committed a criminal offence. By implication, they are not necessarily guilty and may not have been charged or convicted of an offence. However, this status may impact on how they are treated or managed as 'patients', 'clients' or 'vulnerable' individuals.

2. Policy and commissioning context

Major reforms of public services and of the way they are delivered in England have been underway since the Conservative–Liberal Democrat coalition government was elected in 2010. This commissioning pilot was instituted as part of the former Labour government's policy drive to shift the commissioning of and accountability for criminal justice health and social care to the NHS.

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Improving Health, Supporting Justice[1] recommended new and improved partnerships between the health, social care and criminal justice sectors, along with greater opportunity to engage with the independent, voluntary and community sectors. To some extent, the coalition government extended this policy agenda through its 'Big Society' vision to reduce the size of the State and open up public services to a more diverse range of providers, including charities, social enterprises, private companies and employee-owned cooperatives, who could compete to provide services formerly provided exclusively by statutory organisations.[2,3] Furthermore, the NHS commissioning function has undergone review and reform with the wider reorganisation of NHS management in England.

The former government's *offender pathway* approach to managing 'offenders' in the criminal justice system involved endeavouring to develop and maintain local, seamless and integrated healthcare services, equivalent to those provided for the general population,[4] while recognising the synergy between offending behaviour, social deprivation and poor health.[1,5] For offenders with mental health problems, the *offender mental healthcare pathway* approach[6] was intended to establish services that would bridge criminal justice services and settings. *Improving Health, Supporting Justice*[1] and the *Bradley Review*[7] likewise advocated contiguous, integrated services across community and custody settings.

The central catalyst for integrated and effective services is commissioning. For the criminal justice sector, healthcare commissioning is orchestrated by the NHS Commissioning Board (NHSCB) via Local Area Teams (formerly Partnerships Boards).[8,9,10] World Class Commissioning (WCC) was introduced under the former government to align NHS Organisations with other sectors, enable better procurement of services based on local health need, and forge a governance framework to improve effectiveness, efficiency, accountability and quality.[11] Implicit with the latter was the objective to create a robust system for managing contractual relationships with service providers, where providers would have legal accountability for their services and be required to practice to ethical standards set by commissioners.[11] Additionally, a key objective for criminal justice healthcare commissioning was to impact on reducing re-offending by reversing the downward spiral of poor health within the criminal justice population,[7,11] which remains an objective for the NHS National Commissioning Board.[10]

Under WCC, there were five primary goals for police custody healthcare commissioning[11]:

[1] to facilitate contiguous healthcare services for detainees and victims;
[2] to establish accountability and governance consistent with the Police and Criminal Evidence Act 1984 (PACE)[12];
[3] to bring to custody settings clinical governance and healthcare standards consistent with NHS governance and ethics protocols;
[4] to ensure adequate training and skills for forensic, medico-legal and healthcare professionals; and
[5] to manage and prevent avoidable morbidity and mortality associated with custody.

While these goals were not primary objectives for this evaluation, they provide the policy context for the evaluation's findings.

3. Service delivery and organisation

Police custody is essentially the entry point into the criminal justice system, yet it is not a direct entry point to the NHS. However, under PACE the police are required to provide a clinical response to individuals, regardless of their legal or offender status, if they present with health needs or request access to healthcare. Furthermore, the police must ensure that healthcare providers have access to all available information relevant to a detainee's treatment and care.[7,12]

Custody healthcare services are conventionally organised on a contractual basis between police forces and outsourced (usually private) healthcare providers. The latter provide triage, assessment, acute clinical and primary care, and forensic legal services. Most commonly, custody nurses are employed on a 24-7 shift basis, supported by on-call forensic physicians. The employment of custody nurses has reflected the move towards a principally nurse-led service. Consequently, the role of the custody nurse has evolved and extended with the assimilation for some former forensic physician functions. Custody nurses perform important screening and triage functions, especially being available around the clock to assess and prioritise detainees' clinical needs.[13,14]

The shift towards nurse-led provision and away from a physician-led approach occurred during the late 1990s and early 2000s. This reflected a number of trends including the new Labour government's transfer of prison healthcare to the NHS, the evolution of nursing specialisms within the criminal justice sector and shortcomings identified with regard to former forensic physician-led services[15,16] and their training.[17–24]

Despite the development of custody nursing as a nursing specialism, the Nursing and Midwifery Council has no post-registration professional qualification for custody nurses, nor are there agreed professional benchmark specialist skills or competencies for custody nurses.[14] The Royal College of Nursing and the Faculty of Forensic and Legal Medicine recommend custody nurses operate within the requirements of the NMC and of PACE.[25,26] The Association of Chief Police Officers (ACPO)[27] requires custody nurses to be qualified as Registered General Nurses, at a minimum of G-grade (1988 Whitley Council scale), to have four years post qualification experience, three years Accident and Emergency, prison, custody or mental health nursing experience, and to have completed an Intermediate Life Support Course. Additional desirable factors include experience in the fields of substance misuse, minor injuries and first contact care, and of working in an autonomous capacity, for example in primary care or as a nurse practitioner.[26] It remains uncertain how much custody nursing should extend to specialist forensic and legal functions performed by forensic physicians.[26] The Audit Commission[15] has distinguished forensic from non-forensic skills, the former accounting for around 15% of a forensic physician's workload, two thirds of which involves assessments for fitness to be detained or interviewed; such responsibilities could be adopted by nurses to reduce costs to the police. The BMA has recommended that further clarification of roles is required in this respect.[28]

The Home Office has stipulated the importance of appropriate training for forensic healthcare practitioners, irrespective of whether they are physicians or nurses,[29] and the BMA and FFLM support the development of adequate, properly accredited education and training to enable health professionals to engage safely and effectively in this work, with certain responsibilities remaining with physicians.[28] Particular forensic and legal functions require specialist medical and medico-legal training,[13,30] which implies that some delineation of professional roles is important for an effective and safe multidisciplinary clinical team. The Centre for Mental Health[31] and the Bradley Review[7] both asserted that greater involvement of the NHS in organising police custody healthcare could help to create more ethical services skilled at assessing and diverting people presenting with complex health and social needs.

The coalition government's vision to develop a mixed economy of healthcare provision, driven by NHS commissioning, raises key questions about accountability, quality and equity. Private sector

companies have managed custody healthcare for over a decade in England. However, market performance, competitiveness and economies of scale determine a provider's ability to survive in the market, bringing potential for adverse impacts on service quality where there are sacrifices or deficits, particularly with regard to training, education, workforce development and terms of service. Integration with NHS governance and quality systems, along with strong allegiance with professional bodies to whom professionals are accountable, are key to the success of commissioning to the private sector.

4. Context and setting of the pilot

To respect the confidentiality of those who participated in the evaluation, and given that this was a politically sensitive development, the identity of the pilot is not revealed. However, the pilot was situated in a predominantly rural county in southern England, with a police force that operates across three 24-hour custody suites in larger towns, nine part-time custody suites in smaller towns, five local police stations and four victim suites. One of the smaller custody suites doubled as prison overspill under Operation Safeguard.[32] The county was also served by two commissioning primary care trusts (PCTs), one with responsibility for criminal justice health service commissioning, including commissioning of services to prisons and young offender institutions locally. The evaluation was focused on the relationships between this commissioning NHS organisation, the county's police force and the private healthcare company that provided forensic healthcare for the police.

At the time of the evaluation, there were well-established partnership arrangements, locally and regionally, between the strategic health authority (SHA), commissioning PCTs and prisons in the region, developed with the transfer of prison healthcare to the NHS in 2005. There was a strong sense of ambition within the regional Public Health team to maximise opportunities to tackle health inequalities by working with local offender populations, in line with the regional offender health plan. As a senior stakeholder explained, "*… I see our role not just to push offenders through the system but to engage with that wider agenda, with other agencies; and the NHS plays a key, key role in that … It's not just about giving someone their methadone to stop them crawling up the walls so we can interview them.*"

Locally, a Partnership Board, chaired by the PCT commissioner, had strategic oversight and accountability for the new commissioning pilot, with representation from NHS Trust providers, the SHA, regional Public Health, the Police Commissioner, the Independent Custody Visiting Association, the Youth Offending Team, the Race Equality Council and the Local Authority (Social Services). An Operational Group, with responsibility for day-to-day management of the outsourced police custody healthcare service, had representation from the police, NHS providers (mental health teams and acute services providers), the private healthcare provider (the company directors and the nursing team), the Ambulance Service and Social Services; it reported directly to the Partnership Board.

Until 2007, the police had independently contracted forensic medical services to various private healthcare providers, which the Police Commissioner described as *"unsatisfactory, unreliable and unsafe"*. The new partnership with the PCT then transferred responsibility for procurement and contracting to the NHS commissioner. Unlike the former contractual relationship with the police, the new provider was now bound by an NHS contract to provide a forensic healthcare service, with a higher level of scrutiny from the commissioning PCT and the Partnership Board. The NHS contract specified a 24-hour nursing presence at the three main custody suites, and nursing cover for the county as a whole (supported with a tele-link system). It also specified a 24-hour on-call forensic physician service. At the time of the evaluation, the private provider employed a Band 7 Nurse Manager, nine Band 6 Registered Nurses and two forensic physicians. The nurses were responsible for triage of detainees referred to them by the custody sergeants and could perform a range of clinical roles, some of which had formerly been forensic physician roles.

5. Evaluation parameters and methodology

The evaluation was jointly funded by the local commissioning PCT and the SHA to provide 'scrutiny' of the commissioning process, focusing particularly on service quality, clinical governance, workforce development, integration with other services, user perspectives, police perspectives, communication and information sharing and record keeping. It was required to focus principally on the commissioning and contractual relationships as opposed to technical aspects of forensic and clinical practice. It was not required to audit the service and, given the relatively short period of nine months to undertake fieldwork, plus political sensitivities concerning what could and could not be measured, the evaluation was not able to measure hard service outcomes, particularly changes in service quality and provision. It was essentially a consultation exercise that raised issues for the local partnership board and the Department of Health.

The evaluation commenced approximately one year into the pilot. It took a 'formative', qualitative approach, based on close observation and interviewing to gather primary data from key 'actors' and stakeholders. Observation entailed spending days, evenings and nights within custody suites, attending partnership board and operational group meetings, conducting in-depth semi-structured interviews with operational staff and local and regional stakeholders. Ongoing dialogue was established with stakeholders, with feedback, repeat questioning and raising of emerging issues, essentially as a 'critical friend'. This inductive, opportunistic approach enabled the evaluation team to get close to the 'action' and to capture views, perceptions and experiences of the various professional groups.

The first phase of the evaluation involved several hours of intensive observation at two large custody suites (covering night shifts and day shifts, mid-week and at weekends). Interviews were conducted on-site with custody sergeants, detention officers, custody nurses, forensic physicians and duty solicitors, and later with Partnership Board and Operational Group members. We were asked not to interview detainees, which was a significant limitation but would have been difficult from an ethical point of view. Various documentation were scrutinised, including local policies, the Partnership Agreement between the police and the PCT, the NHS Contract with the private provider, and minutes from Partnership Board and Operational Group meetings. Later on, follow-up interviews were conducted with key contacts along with further observation at custody suites to confirm or validate earlier observation data. Interview and observation (field notes) data were transcribed and analysed for core themes, while secondary documentation was reviewed and synthesised for content. Emerging themes were then raised as key issues with the Partnership Board, some of which proved controversial and politically sensitive since different 'partners' appeared to be juxtaposed in their value positions and perspectives. These covered six areas: *Interpretations of Commissioning*; *Intersecting Professional Values*; *the Care–Custody Paradox*; *Professional Autonomy*; *Professional Capacity and Capability*; *and Workforce Development.*

6. Key findings of the evaluation

6.1. Interpretations of commissioning

Participants across the different stakeholder groups held varied understandings and judgments of commissioning *per se*, most perceiving it in terms of the formal relationship between the police, the PCT and the private provider – essentially the "glue" that cemented the partnership. Notwithstanding, participants viewed the meaning, the process, the purpose and the product of commissioning in different ways, as a statutory instrument for achieving a wide range of objectives including clinical governance, quality assurance, accountability, service effectiveness, meeting health and social need, tackling social exclusion and inequality, reducing re-offending, ensuring seamless health and social care, and meeting shared professional objectives. Several stakeholders had ambitions for an evolving health service, reflecting the ethos of the contract that stated unequivocally that the service provider should "*provide seamless healthcare for detainees, offenders and victims of crime by integrating health and offender services*", combined with an efficient forensic service.

Senior level stakeholders perceived that the new partnership would engender a higher quality, more effective and appropriate healthcare service, especially becoming linked with the NHS infrastructure. It would then be more feasible to manage detainees with complex health and social problems by linking them with a myriad of public, Third and independent sector services. Such provision would also be underpinned by NHS standards, practices and procedures, tied into a well-established clinical governance framework, and linked into a strong professional and workforce development culture. It was also perceived that NHS commissioning would bring greater accountability via a clearer system of management and governance. An NHS contract would strengthen the provider's commitment to quality and safety. Respondents expressed these service objectives with terms like *"clearer focus", "transparency", "proper clinical governance", "greater accountability"*, and *"professional competence"*.

Varied perspectives on the purpose of the new partnership broadly reflected different professional roles and 'locations'. Judgments varied on the scale and scope of provision, some viewing the service as a basic outsourcing of nurses and on-call forensic physicians sub-contracted on an agency or locum basis. Indeed, operational level police staff perceived the service having a more limited function compared with senior level police representatives who viewed the new partnership as more than a contractual relationship; one stakeholder commented: *"It feels a lot like a contract, but there's a lot of aspirational stuff in there […] We are used to a service contract which states that this is what you are going to get for your money."* Senior level NHS stakeholders with strategic roles perceived an evolving service with mixed team functionality and identity, consistent with the wider criminal justice health policy agenda to address broader health improvement goals, tackle inequalities and reduce reoffending. Interestingly, a year on from the start of the evaluation the PCT commissioner's view had shifted from the notion of a full custody healthcare service with multidisciplinary team to that of a triage, assessment, liaison and referral service, with scaled down team: *"I realise now that because of the time they spend in custody we can't expect to provide a prison-like health service. We need to do a really good assessment of their health needs. The assessment must be robust enough to pick up any needs and refer them on."* This corresponded with the NHS contract, which aimed to maximise referrals out of custody in order to reduce the numbers of 'revolving door' offenders. This apparent lack of preparation and understanding of the NHS commissioner – of the distinction between police and prison cultures and contexts – is probably indicative of the speed of NHS reform at the time combined with limited dialogue and collaboration between different sectors, locally and nationally.

Confusion across professional groups within the hierarchy was revealing in terms of the range of different expectations of the 'new' service, and whether they had faith in it. Some perceived little likelihood of change – *I'll believe it when I see it* – and others were more aspirational – *let's hope for the best*. Both these perspectives suggest participants perceived these developments to be somewhat beyond their control or influence. Operational and managerial staff also perceived that the new 'offender health' commissioning goals – to reduce health inequalities and re-offending – raised unrealistic expectations of an small service dependent upon a renewable contract. A contract essentially establishes an economic and commercial relationship that is arguably limited in scope for evolving a sustainable healthcare strategy against macro policy objectives. Tension was certainly evident during the course of the evaluation between the private provider's pre-occupation with contract-specific logistical demands and the NHS commissioner's broad strategic goals aligned with regional and national policy objectives.

6.2. Intersecting professional values

The formal NHS-police partnership provided conditions for collaboration and innovation. Good partnerships are built on trust, mutual respect, openness, transparency and commitment from all levels of the hierarchy; they should enable partners to work and learn collectively, make best use of resources, and forge a "no surprises" culture.[11]

With this pilot, various confounding factors had to be addressed in the partnership to deliver an effective and quality service. The evaluation revealed competing and sometimes contradictory professional and organisational interests and accountabilities, creating uncertainty over who was responsible for what and the degree to which healthcare professionals could operate autonomously, consistent with their professional values and objectives. This manifested in reduced professional autonomy for custody nurses given the territorial superiority of the police. Police officers and nurses operate from different professional value positions, have distinctive systems of judgment and assessment, and therefore may conceptualise and treat detainees (and victims) differently. One challenge for this service therefore lay in attempting to reconcile professional differences within the hierarchy, between the NHS and the police, between nurses, physicians and police officers, and between local government agencies and a private business; each viewed their role and function, and the detainee or victim, in a particular way. This apparent confusion across professional groups and sectors indicated a significant problem in engagement and effective communication and understanding, which was communicated to the Partnership Board.

Understanding another profession's culture is an important means towards developing effective inter-professional relationships. As Hall[33] has pointed out, professional cultures are derived from core values, beliefs, attitudes, customs and behavioural norms, which are socialised as the individual professional assimilates with the culture, and common values and ideology become performed and reinforced. In this case, it seemed that the process of cultural convergence would be protracted.

"It's going to take time: There are two large organisations trying to sort things and a lot of committees to sit through. The pace is how I would expect it to be. It is a process of cultural change for both organisations. The police have to learn to understand the NHS, and the NHS has to learn to understand the police. The private provider is stuck in the middle and has to please both parties!"

6.3. The care-custody paradox

Providing healthcare within police custody, as with other criminal justice settings, raises questions about the status and rights of detainees, irrespective of their culpability or guilt, especially if under the supervision or care of more than one professional group. It can raise ethical dilemmas for a service employing professionals operating to different goals or agendas, especially when it is unclear whether a detainee's healthcare needs or rights supersede the need to detain or question them.

PACE is an overriding authority on the procedural management of detainees and limits the degree to which police custody can operate as a healthcare setting.[12] The Department of Health and the Home Office support an integrated approach, but PACE restricts the degree to which healthcare professionals can operate autonomously in making independent healthcare decisions about detainees; nurses in particular do not have the authority to over-rule a police decision on healthcare grounds.[12] In this regard, NHS commissioning introduces an accountability dilemma, where professional roles and responsibilities compete with those of the police. Under the former police contract pre-NHS commissioning, healthcare staff effectively worked for the police and therefore responded to proprieties set by the police. Given this change of accountability for the healthcare function, an important question emerged from the evaluation regarding the status of detainees: *'Can an NHS commissioned service effectively safeguard the rights and status of detainees as patients or vulnerable individuals, given their status as detainees?'* In theory, an individual detainee's status and rights as a 'patient' are only acknowledged once a healthcare provider enters the scenario. Therefore, if custody nursing functions to assess the healthcare needs of *all* individuals entering custody, healthcare rights and status should be conferred when the detainee first enters custody or is arrested or detained by the police; otherwise, detainees who are referred to a healthcare provider are only granted those rights and status at the point of referral. Differential status in this regard then incurs differential rights in relation to healthcare ethics, especially in relation to 'need', 'consent', 'privacy', 'confidentiality', and 'respect', and in terms of the role of the professional in providing support, care and advocacy.

The Decency Agenda was introduced to prisons as a mechanism for ensuring safe and dignified conditions for prisoners. Two key objectives were to reduce the suicide rate and to improve the way prisons upheld the rights of prisoners and staff, especially in relation to race equality.[34] This should imply that conditions of custody for any individual in any setting should be safe and humane, respect individuals' rights to care and dignity, and professionals should be able to uphold their respective duties of care. The Decency Agenda has not been extended to police custody, but the principle of decency (with its emphasis on rights and equal opportunities) is central to clinical governance and to the criminal justice public health approach advocated by the World Health Organisation.[35]

Detainees' rights under PACE furthermore do not correspond with those of patients within the NHS; there is a key tension between the principles of *care* and *custody* and their operationalisation, despite the policy goal of equivalence in healthcare provision for the criminal justice population. For police custody detainees to realise their rights as patients under PACE, healthcare professionals arguably need to be able to function as advocates for detainees and be granted unrestricted access to new arrivals, to enable their healthcare needs to be assessed under a system of universal triage. This implies various possible models of provision:

i. a *conventional model*, where new detainees are not automatically considered to have healthcare needs. Healthcare professionals then respond to custody sergeants' judgments and preliminary assessments. Referrals occur on an emergent or reactive basis, as detainees are 'screened' in and referred to healthcare professionals.
ii. a *primary care model*, where detainees are automatically presumed to have healthcare needs and to be at heightened risk of poor or deteriorating health. Healthcare professionals therefore screen all new detainees to determine if intervention or referral are required.
iii. a *public health model*, a proactive approach where healthcare, social care and public health are engaged on a needs-led basis. This approach has broad objectives of acute treatment and referral, harm reduction, social and welfare support, safeguarding intervention and health promotion, and assumes many detainees will present with complex health and social needs. A multi-agency team would be required to provide treatment, care and referral.

While the Public Health model is ambitious, it reflects broader 'offender health' policy goals and the principles that underpin Joint Strategic Needs Assessment, World Class Commissioning and the World Health Organisation's justice health strategy.[11,35]

6.4. Professional autonomy

Under the conventional approach to police custody healthcare, acute medical services are outsourced to external – usually private agency or locum – providers. The healthcare specialist is invited into a setting where the police have overall jurisdiction (under PACE) and hence the police custody sergeant will make the initial clinical judgment before referring a detainee on, an approach that is applied when nurses are on site. As suggested, custody settings are not therefore perceived as healthcare settings, which makes it difficult to build a professional culture of shared values between healthcare and police staff.

Custody nurses and forensic physicians are required to adhere to established professional codes of practice, clinical procedures, protocols and NHS clinical governance guidelines. However, healthcare professionals employed in a private capacity have no direct allegiance or accountability to the NHS – even to the commissioner whose relationship is with the commercial provider and not its workforce. Custody nurses interviewed for this evaluation felt overwhelmingly that their independence from the NHS made them feel professionally isolated, especially due to the temporary nature of their employment (short-term, renewable contract) and the absence of professional development opportunities (a theme revisited shortly). Alongside police staff, custody nurses tended to function in isolation, in deference to custody sergeants, with limited professional autonomy in terms of their ability to make independent clinical decisions: *"We don't have a lot to do with what goes on out there; that's nothing to do with us. We're only here as medical people, we don't have anything to do with the custody side of things … The sergeants make the ultimate decisions."*

6.5. Professional capacity and capability

Central to the commissioning arrangement of this pilot was the NHS contract between the Partnership Board and the private provider, a legally binding agreement which specified the required standard of service. The first phase of fieldwork revealed deficiencies in the service, particularly in the level of custody nursing cover across sites. During the course of the evaluation, such issues were raised with the Board and with the provider – consistent with the evaluation team's 'critical friend' status – and changes were gradually introduced by the provider.

The Partnership Agreement confirmed that custody nursing cover would be provided for all the large custody suites 24 hours a day, 7 days a week for 365 days a year. Specifically, the provider was contracted to respond to all healthcare referrals from custody sergeants within a 45 minute time frame. During the evaluation, concerns were expressed by the police and by healthcare staff over the provider's ability to meet this standard. This emanated from what emerged as staff shortages due to on-going problems with recruitment and retention of custody nurses. Low staffing levels were a key concern for the police:

> *"To allow the service to develop in the way that's hoped, to allow the health screening to happen and to allow the healthcare pathways to develop appropriately, will only be possible if we have three nurses in three suites 24/7… Otherwise, there will be too much travelling to and from each site by the nurses and they won't have time to devote to care pathways. I think this is really quite instrumental in making the whole process work."*

The evaluation revealed that staff morale and status were key factors in staff retention. Attrition of the staff base had the further effect of eroding morale, particularly as there was insufficient staff capacity to provide nurses at all the main custody suites. Custody sergeants then had to suspend judgments on detainees with health problems, which impacted on those nurses who had to provide cover for more than one site. It should be noted that the county covers approximately 1000 square miles and is approximately 60 miles across. Custody nurses expressed frustration at having to work alone across a wide geographic area.

Morale was also impacted on by a range of other factors that included their self-perceived subordinate status relative to the police, the 12 hour shift pattern, the occasional consecutive shifts to cover for staff shortages, the absence of annual leave or sick pay entitlements, the lack of career or promotion opportunities, and the absence of in-service training opportunities. Working environments prevented them from carrying out their roles adequately and safely. In terms of the recruitment process, it was suggested that the vetting process for new staff applicants was unacceptably slow, hindering recruitment of new staff. These issues may only be characteristic of this pilot/locality, but they do suggest something about the relatively poor or subordinate 'cinderella' status of custody nurses more generally, which could be overcome by ensuring that nurses employed in this capacity are experienced and have sufficient seniority to practice autonomously.

Another issue for nursing staff was their evident shifting role and repertoire of responsibilities, as they took on an increasing range of professional functions, despite having apparent limited professional autonomy and being restricted to a narrow pay band. There were mixed views among nurses and police staff regarding the appropriate skills mix for custody nurses. This was partly because recruits were employed from different specialist nursing backgrounds (e.g. mental health; accident and emergency; intensive care; prison healthcare; primary care; etc.), with no evident consistency. There was apparent inconsistency between individual nurses in terms of the practices and procedures they would perform, which, on the whole, reflected different levels of confidence and competence. Moreover, certain procedures they had carried out routinely at NHS sites they were not permitted to perform within police custody settings. This analysis of the experiences of custody nurses involved with the pilot, led to the development of a series of questions that were subsequently raised with the Partnership Board:

- What is an appropriate custody nursing skills mix?
- Where is the clinical boundary between the custody nurse and the forensic physician?
- Should custody nurses share a standard skills mix and competency threshold?
- Should custody nurses be employed at a single pay scale?
- Should the healthcare team be restricted to custody nurses and forensic physicians?
- What level of managerial responsibility should custody nurses have?
- Is custody healthcare a situated healthcare service or a specialist practitioner function?
- Can the professional status of custody nurses be harmonized with that of their NHS counterparts?

One consequence of feedback to the commissioner was that a custody nursing skills mix review was undertaken, which revealed that most nurses possessed a good range of clinical skills and experience suited to non-forensic healthcare settings (e.g. venepuncture, taking tissue specimens, administering controlled drugs, etc.), which, for legal reasons, could only be undertaken by forensic physicians within police custody settings; this caused delays and was argued to be costly. This suggests that further review of current guidelines and practices for custody healthcare staff may be required to ensure the correct balance of skills, grading and training.

6.6. Workforce development

At the time of the evaluation, many stakeholders questioned the extent to which quite meagre funding could realistically and adequately support the development of an effective custody healthcare service, especially give aspirations to integrate custody healthcare into regional and national offender healthcare strategies. There was uncertainty and inconsistency across stakeholders about the *range* of service that should be delivered and *who* should deliver it. It should be noted that the commissioner was restricted to an annual budget from the police of approximately £1 million to commission the service, serving a population of around £750,000.

The "marginal" or "detached" status of healthcare professionals relative to their NHS counterparts was raised by a range of interviewees during this evaluation. The viability of the service was felt to be at risk where employees did not share comparable terms and conditions of service to their counterparts in the NHS. The contract with the private provider stipulated that all employees must be adequately trained to perform their roles, yet there was no provision for in-service training and their location outside the NHS meant that staff felt professionally isolated. There was no discernible workforce development strategy, which was perceived to arise from what was felt to be a meagre budget for custody healthcare and the commitment to commissioning a small independent provider. This impacted on the provider's capacity to attract and recruit new staff: *"It's difficult to entice someone away from the NHS, especially with the pay and pension that we don't get working for this private company. It's difficult to jump ship because they will lose all the benefits."* The contract with a small company did not allow scope for workforce development on an equivalent basis to the NHS, although this should arguably be a priority for regional and national strategy. There is certainly potential with this scale of procurement, but it needs to be supported by robust regional and national policy infrastructures.

As suggested, an overriding issue was the capacity and capability of the custody nursing workforce to provide an effective healthcare service, which is connected to a wider concern regarding the absence of regional and national healthcare workforce development strategies for the criminal justice system. This problem is paralleled within the prison estate, where healthcare

professionals can feel distanced and marginalised from the mainstream NHS workforce. There is currently no dedicated specialist training for healthcare professionals to work in criminal justice settings, although there are continuing professional development opportunities available at some universities in the UK and validated forensic training is available for forensic physicians and practitioners on a voluntary basis.[26,36] Independent sector providers need to be committed to the development of their workforces and towards supporting employees seeking further qualification and career advancement. This will likely depend on the scale of respective providers and the resources they are able or willing to commit. Commissioners perhaps have the power to build contractual relationships with broad, long term vision or investment potential.

The experience of this pilot suggests that national policy may have been running ahead of itself in terms of the absence of the development of a sustainable workforce development strategy. Macro 'offender health' strategy must take seriously economies of scale, where small and large independent providers have a contribution to make, and must consider how to best build the criminal justice healthcare workforce irrespective of local contractual arrangements.

7. Beyond commissioning

"With hindsight the expectation of what could be delivered within the financial envelope was unrealistic."

World Class Commissioning was the former government's goal for NHS procurement, which envisaged outsourced services becoming increasingly regulated by public sector purchasers. This evaluation examined the development of a police custody healthcare service against this NHS commissioning context.

As discussed, commissioning defines relationships in economic terms. Nested within the commissioning process is the procurement phase in which the 'customer' defines the need, the 'contractor' (provider) supplies the service and payment is duly made. The relationship is regulated by contract, and accountability is underpinned by economic sanction. Central to commissioning is the purchaser-provider principle, where the purchaser must represent the 'intelligent customer' and, in issuing the contract, be sufficiently knowledgeable about the area of provision to be able to specify the work to be done.[11] This presumes that definition of the problem and its solution lies with the customer, with little room for negotiation. In the case of NHS commissioning, control lies with NHS managers, and will tend to be shaped by NHS policy agendas. This is equivalent to a target-setting process supported by performance oversight. Commissioning usually implies external procurement, and the coherence of the relationship and of the work carried out is judged through the provider's compliance with the specifications of the contract.

The alternative to commissioning is an in-house professional rather than economic relationship. The manager may set broad strategic aims and specify the service to be delivered, which will tend to be driven by local needs, conditions, complexities and priorities. Coherence is judged by correspondence of the intervention with local conditions. In the case of police custody healthcare, this would consist, for example, of a team being identified within the NHS and assigned on a project basis to develop the specialism. Dedicated staff would be responsible both for providing the service and exploring its boundaries. With this model there is an emphasis on clinical management – i.e. oversight of both professional practice and professional development. In accountability terms, since the professional model relies on the judgment of the practitioner, there are relatively high levels of professional autonomy and a high-trust approach to accountability.

Developments in police custody healthcare must be viewed within the wider political context. The national policy framework articulated by Bradley[7] was orientated towards a 'pathway' model of criminal justice health and social care, which was consistent with the former government's approach to offender management. Under this model, the NHS was envisaged as having a central role in developing and governing health and social care services across the criminal justice system, through partnerships with lead organisations. The objectives were to establish quality, effectiveness and integration to meet the needs of local populations. However, the ease with which Bradley advocated service integration underestimates the complexity of melding professional and organisational cultures – what in other areas of public service have so far proved intractable to varying degrees. For example, the separation of the Ministry of Justice from the Home Office – separating out offender management and policing – merely added to the complexity of interdepartmental negotiations embracing the Department of Health. Commissioning these services would represent the transfer of funds on a large and potentially expanding scale from police budgets (Home Office) to the NHS (DH) with significant oversight responsibilities for the Ministry of Justice.

Fragmentation at the political level intensifies the challenges of partnership development at local levels. In the case of this pilot, there was an *evolving* (not stable-state) relationship between the police and the NHS, occurring within an organisational context of differing professional values and ideologies. Two traditionally distinct public service cultures were endeavouring to work collectively whilst upholding their respective core values and principles around 'care' and 'custody', responding to sometimes quite separate policy agendas underpinned by PACE and the NHS Governance Framework. Other institutional and professional challenges arose in terms of how the different sectors and professional groups intersected: the police, nurses, forensic physicians, other health and social care practitioners, legal colleagues and Third sector agencies, all with differing organisational imperatives and guided by their respective codes and principles. The key challenge for commissioners, and indeed for stakeholders at all levels, is to create synergy between partners, where they can work effectively together on common goals. At the time of this pilot, the broad commissioning goal was to forge healthy, supportive and safe custody environments, whilst meeting the ethical standards of the Home Office, the Ministry of Justice, the NHS and lead professional bodies, and supporting the rights, status and needs of detainees, victims, professionals, the public and the institutions themselves. This remains an ambitious project and presents a major challenge for new criminal justice health and social care partnerships. Stakeholders in this local project were in agreement that having an NHS commissioned service could make a difference:

> *"I think when you get a good service, your expectations rise and your aspirations rise. I have to remind my staff now and then about what we used to get and what we get now."*

Conflict of interest

The author declares that there are no conflicts of interest relating to this submission.

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Ethical approval/permissions

Ethical approval for the evaluation was granted by the University of the West of England, Bristol's Research Ethics Committee. Participant information was provided to all those approached during the evaluation and signed consent obtained from those

directly involved in the fieldwork, either as interviewees or as subjects of observation. The ethics committee would not permit access to detainees, however, although the stakeholders would have preferred this to happen. For ethical and legal reasons, the identity of the pilot is not disclosed, especially given the small numbers of identifiable participants and potential vulnerability of the various agencies involved.

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References

1. Department of Health. *Improving health, supporting justice*. London: Stationary Office; 2007.
2. Cabinet Office. *Giving white paper. Cm 8084*. London: Stationary Office; 2011.
3. House of Commons Public Administration Select Committee. *The Big Society: 17th Report of Session 2010–12*. London: Stationery Office. Available from: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmpubadm/902/902.pdf; 2011 [accessed 20.01.12].
4. National Offender Management Service. *The national reducing re-offending delivery plan*. London: Home Office; 2005.
5. Social Exclusion Unit. *Reducing re-offending by ex-prisoners*. London: Social Exclusion Unit; 2003.
6. Department of Health. *Offender mental health care pathway*. London: DH; 2005.
7. Bradley K. *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health; 2009.
8. Department of Health. *Equity and excellence: liberating the NHS*. London: Stationary Office; 2010.
9. Home Office. *Policing in the 21st Century: re-connecting the police and the people*. London: Stationary Office. Available from: http://www.homeoffice.gov.uk/publications/consultations/policing-21st-century/policing-21st-full-pdf; 2010 [accessed 20.01.12].
10. NHS Commissioning Unit. *Our NHS care objectives: a draft mandate to the NHS Commissioning Board*. London: Department of Health; 2012.
11. Department of Health. *World class commissioning: competencies*. London: Stationary Office; 2007.
12. Home Office. *Police and Criminal Evidence Act 1984 (PACE) and accompanying Codes of Practice*. London: Stationary Office. Available from: http://www.legislation.gov.uk/ukpga/1984/60/section/1; 2008 [accessed 29.05.12].
13. Bond P, Kingston P, Nevill A. Operational efficiency of health care in police custody suites: comparison of nursing and medical provision. *J Adv Nurs* 2007;**60**(2):127–34.
14. Gannon S. *Assessment report on the Kent custody nurse scheme*. London: Home Office; 2002.
15. Audit Commission. *The Doctor's Bill: the provision of forensic medical services to the police*. London: Audit Commission; 1998.
16. Kutchinsky N. *Development programme for extending detainee healthcare support: early interventions workstream, final report*. London: Revolving Doors Agency; 2006.
17. Rix KJ. Continuing education needed for forensic medical examiners. *BMJ* 1993;**306**:861–961.
18. Davis N. Treating drug addicts in police custody. *BMJ* 1993;**306**:1342–3.
19. Stark MM. Management of drug misusers in police custody. *J Roy Soc Med* 1994 October;**87**(10):584–7.
20. Laing J. The police surgeon and mentally disordered suspects: an adequate safeguard? PhD thesis, University of Leeds; 1996.
21. Best D, Havis S, Payne-James JJ, Stark MM. Near miss incidents in police custody suites in London in 2003: a feasibility study. *J Clin Forensic Med* 2006;**13**:60–4.
22. Stark MM. *Home office prisoners: recommendations for forensic physicians*. London: Faculty of Forensic and Legal Medicine; 2006.
23. Wall IF, Jenkins D. Lack of training in custodial medicine in the UK: a cause for concern? *J Forensic Legal Med* 2008;**15**(6):378–81.
24. Stark MM, Norfolk G. Training in clinical forensic medicine in the UK: perceptions of current regulatory standards. *J Forensic Legal Med* 2011;**18**(I6):264–75.
25. Royal College of Nursing. *Health and nursing care in the criminal justice service: guidance for nursing staff*. London: RCN; 2009.
26. Randle J, Fewkes S, Stark M. *The role of the healthcare professional*. Faculty of Forensic & Legal Medicine; 2012.
27. Association of Chief Police Officers. *Guidance on the safer detention and handling of prisons in police custody*. London: Home Office; 2006.
28. British Medical Association. *Health care of detainees in police stations: guidance from the BMA Medical Ethics Department and the Faculty of Forensic and Legal Medicine*. London: BMA; 2009.
29. Home Office. *Report of the Home Office Working Group on Police Surgeons. Annex D*. London: Home Office; 2001.
30. Payne-James JJ, Green PG, Green M, McLachlan GMC, Munro MHWN, Moore T. Healthcare issues of detainees in police custody in London, UK. *J Forensic Legal Med* 2008:17.
31. Sainsbury Centre for Mental Health. *Briefing 36: the police and mental health*. London: Sainsbury Centre for Mental Health; 2008.
32. HM Prison Service. *Prison service instruction 30/2006: operation safeguard*. London: HMPS; 2006.
33. Hall P. Interprofessional teamwork: professional cultures as barriers. *J Interprof Care* 2005;**19**(1):188–96.
34. HM Prison Service. *Professional standards statement*. London: HM Prison Service. Available from: http://www.justice.gov.uk/search?collection=moj-matrix-dev-web&form=simple&profile=_default&query=PSO+1215; 2007 [accessed 29.05.12].
35. World Health Organisation. *Declaration on prison health as a part of public health*. Copenhagen: WHO Regional Office for Europe; 2003.
36. Faculty of Forensic and Legal Medicine. *A guide to practical induction training in clinical forensic medicine*. London: FFLM; 2007.